| UnitedHealthcare Community Plan | Healthy Blue | Aetna Better Health | LHCC | AmeriHealth Caritas |
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| "Any new member received via an 834 eligibility file with a retro-active Effective Date is systematically placed into 2 distinct groups within our system:<br><br>The first is a "Transition of Care" group, and the member remains here for the duration of their retro period.<br>The benefit and configuration setup within the Transition of Care group contains no Prior Authorization or Precertification requirements, and the claims team has specific instructions to bypass Timely Filing for claims with DOS within this group.<br>The timeline for the Transition of Care group begins on the member's Effective Date, and ends on the last day of the month that we received the member on the 834. | Healthy Blue is following all of the guidelines. We also sent out a Provider Update notifying providers of the change. Below is a snapshot of our Retroactive Member Enrollment process. 1. Healthy Blue determines timely filing from the date transmitted from LDH on the 834<br>a. The effective date and the LDH notification date is placed in Facets on the Claims Pay Hold tab application<br>2. When a claim comes in that falls on or between the eligibility date and the LDH notification, the claims team receives a warning message to review retro eligibility<br>3. The claim analyst reviews the Claim Pay Hold tab application to verify if the date of service falls within the approved range. If so, then the claim analyst will override timely filing as long as the received date of the claim is within 12 months of the LDH notification/834 date.<br>4. If the service requires an authorization, and medical records are attached, then the medical records are forwarded to a nurse for medical necessity review.<br>a. If the nurse deems the service medically necessary then the claim is paid<br>b. If the nurse deems the service not medically necessary, then the claim is denied as not medical necessary.<br>5. If the service requires an authorization, and the medical records are not attached, then the claim is denied for medical records.<br>a. When the medical records are received, Step 4 a-b will occur | Aetna Better Health is confirming receipt of the HPA 16-31. A process for identifying retro-members and desktop instructions created. The provider community will not need to do anything different with their claim submissions.<br><br>The pre check run query developed looks at the date of service on the claim to determine if the member's enrollment effective date is after the date of service and prior to a termination date, (if one is present). If the date of service is within 12 months of the created timestamp from the MCO linkage add date (date member entered in system) the claim is pend on the claims report for the processor to work.<br><br>The desktop instructs the processor, to override the timely filing edit continue processing the claim per standard procedure and if prior authorization edit fires override the edit and finalize the claim. | In response to the requirements of HPA 16-31, we have put certain processes and system changes into place in order to effectuate the requirements of HPA 16-31. On a routine basis, we review each of the new members we receive on the 834 and identify the new retroactive members. For the members who are identified, we have developed a new workflow for any claims associated with these members. The new workflow allows for us to ensure that the claims associated with these members are not denied for timely filing, prior authorization or precertification edits. Pursuant to the HPA, certain claims may be pended until completion of a medical necessity review. | Timely filing logic has been updated to identify and capture claims for this segment to ensure they do not deny as untimely. This was implemented in December 2016. Prior authorization bypass, however, is still pending. That process should be implemented no later than March 2017. In the meantime, we have implemented a workaround which entails a manual claims process to ensure these claims bypass the PA requirement. |